

Practitioner attitudes in the United States and United Kingdom toward decisions at the end of life: are medical ethicists out of touch?

ABSTRACT ● **Objective** To assess whether UK and US health care professionals share the views of medical ethicists about medical futility, withdrawing or withholding treatment, ordinary or extraordinary interventions, and the doctrine of double effect. ● **Design, subjects, and setting** Answers to a 138-item attitudinal questionnaire completed by 469 UK nurses studying the Open University course on “Death and Dying” were compared with those of a similar questionnaire administered to 759 US nurses and 687 US physicians taking the Hastings Center course on “Decisions Near the End of Life.” ● **Results** Practitioners accept the relevance of concepts widely disparaged by bioethicists: double effect, medical futility, and the distinctions between heroic and ordinary interventions and withholding and withdrawing treatment. Within the UK nurses’ group, the responses of a “rationalist” axis of respondents who describe themselves as having “no religion” are closer to the bioethics consensus on withholding and withdrawing treatment. ● **Conclusions** Professionals’ beliefs differ substantially from the recommendations of their professional bodies and from majority opinion in bioethics. Bioethicists should be cautious about assuming that their opinions will be readily accepted by practitioners.

INTRODUCTION

For the past 30 years, bioethicists’ bread-and-butter has been the critical examination of faulty thinking in biomedical practice. Where stereotypes and muddle prevailed, bioethicists have seen it as their task to bring philosophical clarity. On the face of it, this is an admirable task, but some professional reputations have been built on clever hypotheticals with little relation to everyday practice.¹ Furthermore, consequentialist approaches have tended to dominate, particularly in the area of death and dying.

For example, the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research and other US official recommendations rejected the distinction between withholding and withdrawing treatment because they have the same effect.^{2,3} The Hastings Center published guidelines on

withdrawing treatment and argue for patient autonomy, which would be violated if physicians always felt an obligation to continue with treatment once initiated, even if the patient changed her mind.^{4(p130)} Similarly, clinicians who think that there is a distinction (and that withdrawing treatment is more serious) may be less likely to initiate potentially useful treatments that they may later have to withdraw. Both these arguments are drawn from ethical consequentialism. By contrast, other approaches, such as narrative ethics,⁵⁻⁸ hermeneutics,^{9,10} the ethics of care,¹¹⁻¹³ or a power model,¹⁴ might view withdrawing care as different from withholding it: new relationships and expectations have been built up during the period in which care has been offered.

Likewise, the consensus in biomedical ethics has generally been against the distinction between ordinary and extraordinary treatment. Whereas extraordinary treatment

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Funding: Kellogg
Foundation

Competing interests:
None declared

This article was
originally published in
J Med Ethics
2000;26:254-260.

can permissibly be forgone, in Catholic theology, ordinary treatment cannot.^{15(p138)} As stated by Cardinal Jean Villot, Vatican Secretary of State, in 1970, the same distinction applies to physicians' duties as to patients^{16(p75)}:

A medical man does not have to use all the techniques of survival offered him by a constantly creative science. In many cases, would it not be useless torture to impose vegetative resuscitation in the final stages of an incurable sickness?

However, what was extraordinary in 1970, when Cardinal Villot made his pronouncement, may now be ordinary. With the fluid boundary between what is technologically extraordinary one day and perfectly standard practice the next, there is some practical basis for skepticism about the distinction, but many writers in bioethics have concentrated on the philosophical incoherence of the contrast instead.¹⁷ Other once-standard distinctions that have come in for "demolition" include those between "active" and "passive" euthanasia¹⁸ and between relieving suffering versus shortening life, as in the doctrine of double effect.¹⁹

The concept of medical futility has been a particular focus of controversy.²⁰⁻²³ Because an underpinning definition of futility is crucial to decisions about withholding or stopping interventions, and because the greatest problem in American practice has often been seen as the tendency toward excessive interventions, futility has been a linchpin concept. Yet, bioethicists have been suspicious of futility as merely a rationalization or as "too ambiguous and pejorative a term."²⁴

Do physicians and nurses still use the concepts that many bioethicists have done their best to discredit? If so, do they do so out of ignorance, or is there a coherent pattern to their attitudes on decisions in death and dying—evidence, perhaps, of another sort of consensus than the bioethical one. In short, is bioethics in touch with what practitioners really think?

METHODS

For an in-hospital ethics training program on "Decisions Near the End of Life," the Hastings Center, Briarcliff Manor, NY, and the Education Development Center, Newton, MA, developed a questionnaire on practitioners' attitudes toward ethical issues in death and dying, funded by the Kellogg Foundation. This "institutional profile" was piloted with 72 subjects and reviewed by an external panel of experts in clinical ethics, sociology, anthropology, health services research, psychology, and statistics. A second survey was administered 2 months later ($n = 52$). Test reliability was estimated as good, using several different techniques.²⁵ After this piloting process, the questionnaire

was administered at 5 test hospitals ranging in size from 180 to 660 beds. The total numbers responding were 759 nurses and 687 physicians (369 internists, 174 surgeons, and 144 house officers).

For the Hastings Center, the primary purpose of the questionnaire was to "ground" the work that practitioners would be doing in their 6-session training program by forcing them to define at the outset their own attitudes, values, and ethical beliefs on such issues as withdrawing or withholding ventilation, artificial hydration and nutrition, and cardiopulmonary resuscitation. For the Education Development Center, the prime interest was in compiling an expanding database reflecting current US practitioner attitudes toward issues around assisting death and letting die.²⁶

I developed a UK version of the questionnaire for an Open University course on "Death and Dying," again with both pedagogic and research objectives. Following a pilot run with 43 UK practitioners, the questionnaire was completed by 469 UK hospital and hospice nurses who were students on the Open University course between 1993 and 1997. (Although some questions from the US instrument were eliminated or redrafted to suit UK practice, the questions in the tables below used exactly the same wording, with 3 minor exceptions [tables 1, 2, and 10] in which the UK version appears in parentheses.)

Completion of the questionnaire was optional on the Open University course, unlike the US counterpart, making numbers somewhat lower. In particular, there were too few physicians for statistical analysis. No responses from UK doctors appear in the findings reported in this article, although findings concerning US physicians have been included for interest and, in some cases, for reporting comparisons between professions in the United States.

The UK group includes a larger proportion of hospice nurses than the US sample and, therefore, probably a higher exposure to critically or terminally ill patients. However, the US and UK nurse groups both encountered the questionnaire early in their study, so that untutored responses were being measured. The nurse groups are also broadly comparable in means for age (US = 39.5 years, and UK = 38.0 years) and number of years in the nursing profession (US = 13.9 years, and UK = 15.6 years).

Although further research is desirable to ascertain UK physicians' attitudes, UK nurses, of all British practitioner groups, may well give us the best idea of how relevant to terminal care are the concepts of double effect, futility, and heroic versus ordinary treatment. The US findings showed that nurses had the greatest amount of contact with dying people and surgical attending physicians the least. Nursing ethics, heavily influenced by the ethics of care,²⁷⁻³⁰ may also be particularly reluctant to accept the authority of the biomedical ethics establishment on such questions as withdrawing and withholding.

Table 1 *Practitioner acceptance of the concepts of medical futility and extraordinary versus ordinary treatments**

Question	1 Strongly disagree	2	3	4	5 Strongly agree	Means
Heroic distinction useful	3 (4)	8 (7)	19 (19)	43 (31)	26 (39)	3.80 (3.92)
Futility guidelines needed	1 (4)	5 (7)	15 (19)	38 (32)	41 (39)	4.12 (3.94)
Dying agree	23 (18)	42 (33)	18 (28)	15 (17)	2 (5)	2.32 (2.57)
Futile treatment not required	5 (26)	13 (25)	27 (19)	37 (14)	17 (16)	3.48 (2.67)

*Values are percentages of UK nurses replying under each category and overall means (with figure for US physicians and nurses in parentheses) on a scale of 1 to 5 (strongly disagree to strongly agree) to the following questions:

- The distinction between extraordinary (or heroic) measures and ordinary treatments is helpful in making termination of treatment decisions
- Clinicians need better guidelines to help determine when treatments are medically futile
- Clinicians and patients (UK: dying people) generally agree about what constitutes medically futile treatment
- Clinicians are not required to provide medically futile treatment, even if a terminally ill patient or family member demands it.

RESULTS AND DISCUSSION

Medical futility and extraordinary treatment

Question 1 of table 1 shows 69% (UK nurses) and 70% (US overall) agreeing or strongly agreeing that the distinction between extraordinary and ordinary treatment measures is useful, with 11% in both countries disagreeing. (In fact, this agreement prevails across all US professional groups: medical attending physicians [mean = 3.88], surgical attendings [mean = 4.06], house officers [mean = 3.89], and nurses [mean = 4.02]).^{26(table 4)}

Consistent with this distinction, which implies that extraordinary measures are not required because they impose disproportionate burdens with minimal results, clinicians in both countries favor stronger guidelines on

medical futility from professional bodies. (The survey was administered before the British Medical Association [BMA] guidelines on withdrawing and withholding treatment were published in September 1999.) This result for question 2, table 1, is interesting because the awareness of existing guidelines is reasonably high in both national groups—although consistently higher in the United States (table 2).

Item 3 of table 1 shows that 65% and 61% of clinicians (UK and US, respectively) disagree or disagree strongly with the statement, “Clinicians and dying people generally agree about what constitutes medically futile treatment.” Only 2% and 5%, respectively, strongly agree that they normally reach an accord with dying people and their families about whether to continue aggressive interventions. In question 4 of table 1, US and UK practitioners disagree sharply about whether clinicians must provide medically futile treatment if dying people and their

Table 2 *Awareness of guidelines*

Percentage replying “yes” to the question: Are you aware of any guidelines at your institution about the following:*	
Obtaining DNR orders	88 (64)
Documenting reasons for DNR order	63 (56)
Requests for organ donation	77 (56)
Recording patient's wishes in medical record	69 (72)
Obtaining informed consent	84 (77)
Determining patient's capacity to participate in decisions	61 (40)
Withholding or stopping mechanical ventilation	53 (37)
Withholding or stopping artificial nutrition and hydration	41 (34)
How to proceed when ethical concerns about a patient's care arise	61 (46)

DNR = do not resuscitate.

*Values are for US physicians and nurses overall, with percentages for UK nurses given in parentheses.

Table 3 *Sources of intrastaff conflict identified by UK nurses**

How often do disagreements among staff arise over the following?	
Determination of patients' capacity to make decisions	51.4 (2.54)
Adequacy of the informed consent process	48.8 (2.45)
Use of patients in research projects	30.9 (1.96)
How information is given to patients and families	55.6 (2.63)
Deciding when a treatment is medically futile	60.3 (2.70)
What treatment alternative is best for a patient	58.4 (2.69)
When to consider the economic costs of a patient's care	38.8 (2.20)

*Value are the percentage (with mean score in parentheses) of those answering 3, 4, or 5 on a scale of 1 to 5 = almost never, and 5 = almost always).

Table 4 *Undertreatment and overtreatment in UK and US practice*†*

Treatment variable	UK nurses	US internists	US surgeons	US house officers	US nurses
Treatment burdensome	52 (3.31)	58 (3.43)	45 (3.02)	78 (4.01)	51 (3.34)
Give up too soon	20 (2.33)	15 (2.22)	7 (1.84)	8 (2.05)	12 (2.10)

*Values are the percentage (with mean score in parentheses) answering 3, 4, or 5 to the following question: On a scale where 1 = strongly disagree and 5 = strongly agree, to what degree do you agree or disagree with the following statements:

- Sometimes I feel the treatments I offer my patients are overly burdensome
- Sometimes I feel we give up on patients too soon

†Differences in responses by profession and nationality are significant at $P < 0.001$ (1-way analysis of variance).

families demand it (although further research is necessary to determine the level of significance). This finding contrasts with practitioners' agreement on the "utility of futility": what to do once a treatment has been identified as futile is another matter. Most American practitioners agree or strongly agree that clinicians are required to provide medically futile treatment requested by dying patients or their families. In contrast, 54% of UK nurses agree or strongly agree that medically futile treatment is not obligatory even if patients and families disagree. (English law is generally loath to require physicians to act against their clinical judgment in providing futile treatment.³¹) UK nurses, however, report that futility causes more discord among clinical teams in their country than any other issue, even expensive cardiopulmonary resuscitation (table 3).

Treatment withdrawal

The results so far show that practitioners in both the United Kingdom and the United States rely heavily on the linked concepts of heroic versus ordinary treatment and medical futility, although they may disagree on what to do when patients or their families request treatment that clinicians deem futile. Here practitioners disagree with the bioethics consensus, as they do on withholding and withdrawing treatment (table 4).

Few US practitioners agree that "we give up on patients too soon," consistent with the finding that US physicians will continue offering treatment, even if they judge it medically futile, so long as patients and families want it. The incentive is to overtreat in a largely private system of

health care provision³²—posing particular problems for last-chance therapies and managed care.³³ The UK sample contains a high proportion of hospice nurses to whom the notion of treatment-at-all-costs is likely to be anathema. Palliative care is not seen as treatment withdrawal in hospice philosophy, and aggressive interventions are rejected in favor of a holistic approach to death and dying.

Responses shown in table 5 suggest that UK nurses are the most likely to disagree with accepted bioethical wisdom: only 1 in 5 agree or agree strongly that withholding and stopping treatment are the same in ethical terms. More than 3 in 5 (62%) disagree or disagree strongly with the statement. Overall, only US medical attending physicians are as likely to agree as disagree that there is no ethical difference. Every other group is more likely to disagree than agree with the "official" view, that is, the BMA guidelines of September 1999 and the US guidelines.^{2,3}

Double effect and euthanasia

Some bioethicists, and most supporters of euthanasia, regard the doctrine of double effect as a hypocritical remnant of Catholic moral theology,^{34,35} but it is accepted by many practitioners. In England, the High Court clarified in the 1997 case of Annie Lindsell that existing law could accommodate a general practitioner's willingness, at the request of a woman dying of motor neuron disease, to prescribe analgesic medication in quantities that may shorten her life. As table 6 shows, this judgment confirms what many practitioners already believe.

Only 3% of UK nurses disagreed or strongly disagreed with this statement. Most reject the argument—made by the Voluntary Euthanasia Society in the 1994 hearings before the House of Lords Select Committee on Euthanasia—that it is hypocritical to give analgesics in the knowledge that the patient's death may result, while claiming only to be concerned with pain relief. Likewise, practitioners largely accept the distinction between passive and active euthanasia, distrusted by many bioethicists, to the extent that they see an important moral distinction between stopping treatment and assisting suicide.³⁶ Although the consequences of the 2 actions may be the same, 7 out of 8 practitioners surveyed, across countries and professions, agree or strongly agree that the content of the actions is ethically different (table 7).

Junior physicians in the United States are most likely to agree with this statement, and UK nurses most likely to disagree, although only 11% of the latter disagreed or strongly disagreed with the statement. It is often said that nurses are more unwilling to see treatment stopped than physicians, because they are more intimately involved in patient care. In the case of patient Tony Bland, for example, who was in a persistent vegetative state, nurses initially opposed the decision by the family and consultant

Table 5 *Responses by nationality and profession on the question of whether withdrawing treatment is ethically different from never starting it**

UK nurses	US medical attendings	US surgical attendings	US house officers	US nurses	US overall
20 (2.39)	43 (3.00)	38 (2.84)	44 (2.96)	27 (2.49)	34 (2.71)

*Values are percentage (with mean score in parentheses) agreeing or strongly agreeing on a scale of 1 to 5 (1 = strongly disagree, and 5 = strongly agree) with the statement. There is no difference between withholding (not starting) a life support measure and stopping it once it has been started.

to withdraw artificial nutrition and hydration.³⁷ But both nurses and physicians surveyed reject the argument that because the consequences of treatment withdrawal and assisted suicide are the same, there is no ethical distinction. When the question of disconnecting feeding tubes is tackled more explicitly, a slightly diminished majority of practitioners still uphold the distinction between that and euthanasia, as table 8 indicates.

Patient participation and practitioner satisfaction

On attitudes toward patient autonomy and participation in decision making, UK nurses demonstrate a greater commitment than any of the US groups, as shown in table 9, particularly questions 1 and 2. (Note that a high score on question 1 indicates a strong commitment to letting the patient decide, whereas the opposite is true on questions 2 and 3.) Yet, as table 10 demonstrates, they are also considerably more satisfied with the extent to which these rights are respected in clinical practice. I have explored this interesting and unexpected juxtaposition in greater detail elsewhere³⁸ and only wish to repeat one point here. The authors of the American survey, Solomon et al,²⁶ were puzzled that US practitioners were very dissatisfied with the care received by terminally ill patients, but disagreed with professional bodies' recommendations. UK nurses, like their US medical and nursing colleagues, disagree with such recommendations: To them, withdrawing care is different from withholding it, and futility is a meaningful concept. However, UK nurses are much happier with practice in terminal care (table 10). This suggests that there is no connection between satisfaction or dissatisfaction with patient care and disagreement with the bioethics consensus.

Rationalism, religion, and attitudes toward national guidelines

A substantial number of UK nurses surveyed describe themselves as having no religion. This group, whom I call "rationalists," shows a statistically significant degree of skepticism about the distinction between withholding and withdrawing treatment, but not about the doctrine of double effect concerning unintentionally hastening death (table 11). Although double effect is originally a Catholic doctrine, UK nurses of all religions and those of no religion actually accept it slightly more strongly and more consistently (having a lower standard deviation). This is probably because they have fewer qualms about *intentionally* hastening death than the other 2 groups. On the other 2 questions, the rationalist minority holds views that are significantly different. They are far more likely to agree (with the professional bodies' consensus) that there is no difference between withdrawing treatment once started and not offering it in the first place. And they are more

Table 6 *Practitioner agreement, by nationality and profession, with the doctrine of double effect**

UK nurses	US medical attendings	US surgical attendings	US house officers	US nurses	US overall
94 (4.67)	94 (4.55)	92 (4.52)	92 (4.56)	86 (4.35)	89 (4.44)

*Values are percentage (with mean score in parentheses) agreeing or strongly agreeing, on a scale of 1 to 5 (1 = strongly disagree, and 5 = strongly agree), with the statement: Sometimes it is appropriate to give pain medication to relieve suffering, even if it may hasten a patient's death.

Table 7 *Practitioner agreement with distinction between withholding treatment and assisting suicide, by nationality and profession**

UK nurses	US medical attendings	US surgical attendings	US house officers	US nurses	US overall
87 (4.22)	89 (4.47)	86 (4.44)	94 (4.57)	85 (4.33)	87 (4.41)

*Values are percentage (with mean score in parentheses) of those agreeing or strongly agreeing, on a scale of 1 to 5 (1 = strongly disagree, and 5 = strongly agree), with the statement: To allow patients to die by forgoing or stopping treatment is ethically different from assisting in their suicide.

Table 8 *Practitioner agreement with the statement, "Disconnecting a feeding tube is killing a patient," by nationality and profession**

UK nurses	US medical attendings	US surgical attendings	US house officers	US nurses	US overall
18 (2.22)	11 (1.84)	12 (1.89)	9 (1.62)	12 (1.97)	12 (1.89)

*Values are percentage (with mean score in parentheses) of those agreeing or strongly agreeing, on a scale of 1 to 5 (1 = strongly disagree, and 5 = strongly agree), with the statement.

Table 9 *Attitudes of practitioners, by nationality and profession, about patient involvement in decision making at the end of life**

Decision	UK nurses	US internists	US surgeons	US house officers	US nurses	US overall
Patient can refuse treatment	93 (4.55)	86 (4.39)	87 (4.44)	87 (4.49)	89 (4.52)	87 (4.48)
Want carer to decide	28 (2.74)	56 (3.47)	65 (3.70)	59 (3.55)	50 (3.31)	54 (3.42)
Patients don't want to know	16 (2.44)	29 (2.68)	35 (2.95)	29 (2.18)	19 (2.38)	23 (2.51)

*Values are percentage (with mean score in parentheses) of those answering 4 or 5 on a scale of 1 to 5 (1 = strongly disagree, and 5 = strongly agree), with the following statements

- All competent patients, even if they are not considered terminally ill, have the right to refuse life support, even if that refusal may lead to death
- Many patients prefer to let their caregiver make the decision about what treatment is best
- Many patients prefer not to know they are dying.

Table 10 Practitioners' satisfaction with patient involvement in practice, by nationality and profession**†

Variable	UK nurses	US internists	US surgeons	US house officers	US nurses	US overall
Patients informed	44 (3.11)	49 (3.40)	50 (3.51)	43 (3.23)	25 (2.75)	35 (3.04)
Patients grasp what told	43 (3.12)	42 (3.32)	49 (3.46)	39 (3.22)	26 (2.80)	35 (3.05)
Patients get help to choose	40 (3.05)	43 (3.29)	44 (3.38)	35 (3.08)	26 (2.77)	33 (3.00)
Staff find out patients wish	51 (3.31)	40 (3.22)	39 (3.32)	27 (2.91)	26 (2.79)	31 (2.97)
Wishes recorded	56 (3.43)	37 (3.17)	36 (3.19)	37 (3.19)	21 (2.61)	29 (2.88)
Ethical issues discussed	41 (3.02)	39 (3.16)	31 (3.07)	31 (2.99)	26 (2.69)	31 (2.88)

*Values are percentage (with mean score in parentheses) of those answering 4 (not very satisfied) and 5 (very satisfied) to the question, At your workplace, how satisfied are you about the extent to which

- Patients are informed of different care alternatives?
- Patients understand the information they are told about their condition and treatment alternatives?
- Patients get the help they need to make decisions about care alternatives?
- Staff find out what critically and terminally ill patients want?
- Patients' wishes are recorded in the medical (UK: and nursing) record?
- Ethical issues in a patient's care are discussed by staff?

†Differences by profession and nationality are significant at $P < 0.001$ (1-way analysis of variance).

sympathetic to assisted suicide, a difference significant at $P < 0.001$.

This table (table 11) offers us a suggestive answer to the question of why practitioners' attitudes are intractable to persuasion by national recommendations: These attitudes could correlate with religious belief—or the lack of it. Academic ethicists are likely to be rationalists themselves; others, like Tristram Engelhardt, an active church member, are concerned to develop a common core of principles on which believers and nonbelievers could all agree.³⁹ Does the secular orientation of modern bioethics help to account for the distance between the bioethical consensus and practitioners' beliefs?

CONCLUSIONS

Whether practitioners accept doctrines and concepts widely disparaged by bioethicists says nothing, of course, about

whether they should accept them. To argue otherwise is to fall prey to the naturalistic fallacy ("The mistake . . . of deducing conclusions about what ought to be from premises that state only what is the case: or the other way about," first labeled by G E Moore).⁴⁰ Solomon et al generally assumed that practitioners should not distinguish between withdrawing and withholding care, in the face of national commission recommendations to the contrary. Solomon et al felt that the official bodies' directives, if implemented, would undermine the "technologic imperative" of over-treatment and aggressive intervention at the end of life. But even though US practitioners generally agreed that dying patients were more likely to be overtreated than abandoned too soon, they had not accepted the corollary attitudes that would weaken the grip of the technologic imperative. For example, they were loath to withdraw care once started because they felt that stopping treatment was more serious than withholding it in the first place.

One solution proposed by Solomon et al was that bioethicists should step up their efforts to educate practitioners about national guidelines.²⁶ Solomon and colleagues often appear to accept scientific positivism: bioethics comes across as an activity in which specialists make scientifically validated advances, and practitioners accept them. I want to argue the other way around: practitioners can educate us, and empiric evidence about what they really think can add maturing sophistication to the traditional analytic concerns of bioethics.⁴¹ Medical ethics risks becoming a self-regarding activity if it does not incorporate what practitioners think and do. This is certainly not to say that we should slavishly follow practitioner opinion when we know it to be fuzzy thinking, but neither should we condemn practitioner opinion as misguided. Nor

Table 11 UK nurses' reported religious belief compared with position on withholding or withdrawing treatment, double effect, and assisted suicide*

Statement	Protestant or Catholic (n = 373)†	No religion (n = 62)	P value‡
No ethical difference	2.30 (1.16)	2.81 (1.32)	<0.002
Pain relief appropriate	4.67 (0.76)	4.76 (0.59)	<0.39
Illegal but ethical	3.00 (1.29)	3.77 (1.32)	<0.001

*Values are mean scores (with standard deviation in parentheses) on a scale of 1 to 5 (1 = strongly disagree, and 5 = strongly agree) to the following statements:

- There is no ethical difference between withholding (not starting) a life support measure and stopping it once it has been started
- Sometimes it is appropriate to give pain medication to relieve suffering, even if it may hasten a patient's death
- Although it may be illegal, it is not always unethical to hasten a patient's death upon his or her request.

†No respondents described themselves as Jewish or Muslim; the numbers of Hindu and Buddhist respondents were too small for analysis.

‡Two-sample t test with equal variances for combined Protestant and Catholic groups compared with "no religion" group.

should we try to reduce medical ethics to a positivistic model that we, in our wisdom, can then hand on to clinicians.

Medical ethicists who espouse an a priori model of decision making are more likely to think that practitioners are just plain wrong if they persist in opinions that contradict the collective wisdom of bioethicists. If ethical decision making is a matter of coherent a priori reasoning, then there is no reason to expect practitioners to excel at what they were never trained to do and every reason to think that philosophers will make a better job of it. Conversely, if the facts of actual cases make a difference, and if an empiric model of decision making is preferred, then practitioners can be expected to know something that philosophers do not. If practitioners disagree with national recommendations, that does not necessarily mean that they are ethically ignorant. Although practitioners do show a degree of ignorance of national guidelines, that does not entirely explain the disparity between their beliefs and the bioethics consensus. Perhaps, to paraphrase Thoreau, they simply march to the beat of a different drummer.

We need to know more about why practitioners differ from bioethicists, and from each other, in their attitudes toward decisions near the end of life. These findings are preliminary. Further research is required to ascertain levels of significance for comparisons between US and UK practitioners and to measure the attitudes of UK doctors. Yet, wanting to know more is an important first step: it implies that practitioners' attitudes are not merely misguided, but may reflect alternative and equally valid models. One such alternative model of medical ethics is rooted in phronesis, the Aristotelian concept of the skills of practical judgment.⁶ We would expect practitioners to have particular skills in practical judgment and to have something to teach bioethicists. Whether or not bioethicists want to accept that particular model, they should at least be sensitive to the possibility that they are out of touch.

Acknowledgments: Bruce Jennings of the Hastings Center; Vivian Guilfooy, Karen Heller, Mildred Solomon, and Lydia O'Donnell of the Education Development Center; and Deborah Ridout of the Imperial College statistical consultation service.

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